Where Are We Going in Public Health?

A Labor Leader's Appraisal

LEONARD WOODCOCK

Though the issues, as seen by management and labor are, as one would expect, radically different, there is a surprising and heartening unanimity in the ultimate goals of public health envisioned by both.

Although we in labor are far removed from the technical problems and day-to-day operations of public health, the unions of America and the workers in public health have long been engaged in a common struggle against preventable disease and death. The primary concern of labor unions has been with the elevation of the economic status of the population. The resultant improvement in living standards—the gains in housing, in nutrition, in education—have been key elements in the improved health of the American people.

We in labor are aware of the tremendous contributions made by public health. Public health has made a valiant attack against the major threats to health. First came improvement of the environment—safe water, sanitary sewage disposal, improvement and protection of food, the provision of safe working places, and other measures to assure a safe and healthy environment. The battle against communicable diseases came next and public health turned to such individual health services as immunization, vaccination, and programs for the detection and treatment of tuberculosis and syphilis. Maternal and child health programs involving direct service to the individual also were developed. And public health administration is now turning to the chronic diseases which today comprise a major challenge in health.

There are those in America who are quick to claim all the credit for the phenomenal reduction in mortality in recent years. But we think this improvement flows from many sources—improved technology, advances in the economy and, in the scientific field, as Dr. C.-E. A. Winslow has pointed out, "our major advances have come from scientific research unrelated to the routine practice of medicine and from the operation of highly organized governmentally operated or financed programs."

I do not want to leave you with the impression that labor is entirely satisfied with the public health program of today. In fact, if I were to report on the aspect of public health with which I am in closest contact—industrial health—I would have to point out a definite tendency on the part of labor to look to the state labor departments, rather than to the health departments, for effective action. In part, this has been brought about by better cooperation which we generally receive from state labor departments. Lack of cooperation has, at times, gone so far as refusal by the public health department to make available to the union representatives the results of inspections that the union itself requested. But, more important, local unions find that health departments are simply not doing the job. Without exception, state health and labor departments do not have the staff needed to enforce statutory stand-

ards of occupational health and safety. In Michigan, for instance, investigations are usually made only on a complaint or request basis. The State Health Department's Division of Occupational Health is inadequately financed. The State Department of Labor has even less money for health and safety work, and, as a result, inspection of all places of employment in the state, which is required by law annually, is not carried out even once in five years on the average.

Essential information is being irrevocably lost because of a totally inadequate occupational disease reporting system. In Michigan, for example, where failure to report occupational diseases is a misdemeanor, there is serious underreporting and very little, if anything, is being done to correct the situation.

The President's Commission on the Health Needs of the Nation found that: "the study, control and prevention of occupational health hazards in the United States is not yet on a par with similar activities in other countries. Lack of recognition of the importance of certain industrial diseases, such as skin cancer, stands out in sharp contrast to the unrestricted and wide publicity given this important matter in England, Germany, and Switzerland where these cancers are notifiable and compensable diseases, and information regarding them, therefore, is relatively reliable.

"A great part of the weakness of our industrial health program," the President's Commission stated, "stems from the deep social and economic issues inherent in this field. The plain fact, for example, that the diagnosis of an occupational disease may cause expense to the employer, creates an atmosphere in which science often is subordinated to a desire to minimize or even to suppress knowledge which might prove the relationship of occupational environment to a disease." Only through an impartial publicly administered program can these issues be resolved fairly and in the public interest.

By default of public programs much of the leadership in industrial health has gone to private auspices. Those who are involved in the day-to-day operating decisions and those who conduct private studies have not always been able to extricate themselves from the conflict of interest described by the President's commission. As a result, there is a common tendency to minimize the extent of worker injuries—studies, for example, that attempt to show that loss of hearing is not harmful—perhaps is even desirable. There is a tendency to minimize the employer's liability for industrial injuries and disease, a tendency to exaggerate human factors in causing disability, and widespread suppression of information prejudicial to the employer's financial interest. To counter this, workers must exaggerate their disabilities and the employer's responsibility. This is an uneven struggle in which the employee usually comes out second.

We urgently need a stepped-up program of industrial health. We need improved standards publicly arrived at. We need active and disinterested enforcement of standards. We need responsibly conducted public research on the key problems of industrial health to determine the extent to which cancer, heart disease, and other major disabilities are work-connected. New studies are needed to keep abreast of the changing occupational environment which now exposes people to the risk of radiation and to the hazards of new chemicals and new materials. Improved reporting

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Mr. Woodcock is international vice-president, United Auto Workers, Detroit, Mich.

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and detection programs are needed.

While today's challenge to public health is greater than ever, labor people have the impression that public health is reluctant to tackle new problems. In years gone by, public health met head on the challenge of communicable diseases, although it has not been as courageous in tackling the problems of the occupational environment. In isolated instances physicians like Alice Hamilton provided determined leadership for community action in meeting the industrial hygiene problems of the day. These problems are going to be met. The question before this forum is whether public health will provide leadership to complete the pioneer work of the Alice Hamiltons?

Both labor and public health now face new frontiers in health. Labor unions have developed an interest in health far beyond that of occupational environment. Unions have contributed heavily to the vast growth of prepayment for health services in recent years. Today it is estimated that almost two-thirds of the population have some form of prepaid health protection. Under health programs negotiated by our union alone, over three million workers and dependents have hospitalization and medical coverage. The annual cost of these coverages is about $130 million. Usually the cost is split between the employer and the worker. The employer's share, however, is part of the worker's compensation; it is an item over which his union conducts collective bargaining and it is paid in lieu of increased wages. The union, therefore, has a vital interest in these prepaid health services—a responsibility to see that the worker gets his money's worth. Union negotiations for prepaid health services have only begun. There lie ahead major collective bargaining efforts to deal more effectively with the needs of our membership for more adequate health protection.

The leadership in prepayment, instead of coming from health oriented people, has been provided largely by insurance companies who have subordinated health to actuarial considerations; by insurance agents and brokers motivated primarily by sales; by organized medicine looking for some answer, however inadequate, to the pressures for national health insurance; by hospital organizations concerned mostly with revenue for the purveyors of the service.

Prepayment plans, as they exist in the medical care field, are generally not well designed to promote effectively the health of their subscribers. They overemphasize surgery and sometimes encourage unnecessary operations. They discourage, or exclude, preventive and diagnostic care. There are no adequate controls or standards concerning the quality of the health services furnished, the underwriting, and the actuarial and financial policies. The subscriber pays, but he has little voice in the operation of these mechanisms. Nor has he the professional competence to assay the services for which he pays. Moreover, the steady and continuing inflation in the cost of hospital and medical care has begun to reach alarming proportions. It is becoming evident that those who now control prepayment mechanisms—largely purveyors of service or commercial insurance companies—are not going to exercise the kind of medical controls that must operate if these prepayment systems are to work and to provide health care of high quality at reasonable cost to subscribers. Subscribers are coming to constitute a majority of the population. They are entitled to some measure of protection from government.

Are these efforts by the community to organize for the purchase of hospital and medical care a proper concern for public health? Even the earliest public health laws instruct the state board of health to "have the general supervision of the interests of the health and life of

the citizens of this state." The President's Commission on the Health Needs of the Nation has clearly expressed the only tenable contemporary position of Americans toward personal health services. The commission said, "we have accepted the principle that all persons should have access to comprehensive health services of high quality." And the commission recommended that, "the principle of prepaid health services be accepted as the most feasible method of financing the costs of medical care."

We in labor have long felt, and still feel, that the way to accomplish this objective is through a system of national health insurance. Those who feel that the same objective can be attained through the development of voluntary health insurance programs are now having their day in court. Despite our reservations, we have no choice but to give a fair trial to the so-called voluntary way.

When the practice of curative medicine was a relatively simple matter of treating out of the family doctor's little black bag there was some excuse for public health to ignore personal medical services in the press of fighting epidemics, establishing rudimentary sanitation programs, and developing the other basic public health services. But now that the science and art of medicine have progressed to the point where it takes complicated organization to furnish up-to-date service, the individual consumer cannot cope with modern medical care—its organization, its quality, its adequacy. The citizen is entitled to technical help from his government, especially in a matter as vital as health service.

Public health agencies are standing aside and not making their contribution toward the development of adequate general health care; especially are they derelict in failing to develop comprehensive preventive services. Public health has an inescapable responsibility concerning the quality of care. Public health agencies, for example, should set and enforce standards for the operation of hospitals. Not only do licensing laws need strengthening, but government should see that there is medical evaluation of the quality of care furnished.

There are far too few experiments with forms of medical organization like the Health Insurance Plan of Greater New York, the Kaiser Health Plan in California, and Windsor Medical in Ontario, which actually furnish comprehensive rather than fragmentary services. If we are to take seriously the public health mandate contained in the constitutions and the early laws of most of our states, public health officers should begin to concern themselves with personal health services.

I am not suggesting that the Public Health Service move in and take over operational responsibility for personal health care. Nor am I prepared to indicate the full extent to which their jurisdiction should reach. But I can say that at a minimum these are important areas where public health should now be active.

Public health should conduct programs of research on ways to organize and administer medical care and extend its scope to prevent illness, furnish rehabilitation, and guarantee that institutions and persons licensed to practice do indeed give high quality care. This represents one of the greatest challenges to public health today.

There will be those who say that the movement of public health into the field of personal health services represents the application of some alien philosophy. They may toss about phrases like "socialized medicine." But there is a long tradition in the United States of having government—local, state, and federal—set standards and operate controls for privately provided services for citizens. While they originally were thought to be infringing on liberty, we now accept

public control mechanisms to regulate utility charges, transport fares and freight tariffs, and the purity of drugs among many others.

The people are entitled to and are demanding modern medical care. Substantial numbers of our citizens believe they can get it through national health insurance or even governmentally operated health programs. In the long run the outcome will be determined by whether we make available broad, voluntary prepaid programs whose scope and quality is assured. The challenge to public health is to move into this field as a representative not of the healing arts professions, but on behalf of the citizens.

It seems to me that in his presidential address, Dr. Gaylord W. Anderson at the 1952 convention has thrown this challenge to you in public health, when he said: "Public health is an organized community program designed to prolong efficient human life. It has no artificial limitations that would restrict its activities to certain types of problems. It must deal with and endeavor to combat those forces that tend to impair or to shorten efficient human life and must meet each problem according to its particular needs. The essence of democracy is the concept of rule by the people, who have a right to protect themselves against all forces that lead to illness or to death. As public health workers and servants of the people we have been specifically instructed to 'take cognizance of the interests of health and life among the citizens.' If we neglect or fail to do so we will be derelict in our duty. I am confident as we look ahead to the duties we must assume in the future, we shall not fail."

The citizen needs help with a bewildering array of new health problems. Alone, he cannot cope with them. Law and tradition mark public health as the arm of government which can assure that the scientific and technical advances of modern medicine are extended to all our citizens.

"Armed with new weapons, beginning with the antibiotic 'wonder drugs,' the physician and the public health officer have been able to bring curative and preventive medicine to communities all across the land. For example, with the advent of penicillin, deaths from rheumatic fever have declined 70 per cent. Influenza deaths have been reduced 63 per cent. In addition to human survival and happiness, these advances have made possible billions of dollars in increased national productivity and additional revenue for the state and federal governments. In 1952 alone, the federal Treasury profited by an estimated two hundred and thirty-four million dollars in income and excise tax receipts through the decline in the death rate since 1944."

(Excerpt from the address by Harry S. Truman, November 17, 1955, on the occasion of the annual presentation of the Albert Lasker Awards at the 83rd APHA Annual Meeting in Kansas City, Mo.)